DIVISION OF DEVELOPMENTAL DISABILITIES

SERVICE VERIFICATION

AND

ATTENDANCE RECORD

CASE RESOURCE MANAGER'S NAME

PROGRAM TYPE

- ☐ Family Support
- ☐ Medicaid Personal care
- ☐ Attendant Care
- ☐ Alternative Living
- ☐ VPP Attendant Care
- ☐ VPP Respite Care

CLIENT'S NAME

SERVICE PROVIDER'S NAME

MONTH YEAR

	DATES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
A	**HOUR SERVICE BEGAN**															
B	**HOUR SERVICE ENDED**															
C	**CLIENT TRANSPORTATION**															
D	**PROVIDER MILEAGE**															

	DATES	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	MONTHLY TOTALS
		AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
A	**HOUR SERVICE BEGAN**																	
B	**HOUR SERVICE ENDED**																	
C	**CLIENT TRANSPORTATION**																	
D	**PROVIDER MILEAGE**																	

Signed by: _____

CLIENT/PARENT/GUARDIAN

INSTRUCTIONS:

A. Enter time service began - indicate AM or PM as appropriate.
B. Enter time service ended - indicate AM or PM as appropriate.
C. Client Transportation: All miles traveled transporting a client when authorized per SSPS.
D. Provider Mileage: Enter miles traveled to and from the client for the purpose of providing service when authorized per SSPS.
E. Maintain completed verification forms in your records for six (6) years. Copies may be requested by DDD/DSHS.